

ORDER CERTIFICATION

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS:

- Complete this form and mail it to the following address within **10 days** of the Department's receipt of the hearing decision.

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING MI 48909

SECTION 1 – Case Information:

Case Name		Case Number				
Docket Number	Date of Decision and Order	Co.	Dist.	Sect.	Unit	Wkr.

SECTION 2 – Certification:

☐ I certify that the action(s) contained in the decision and order **were** completed by _____ on _____.
Name of Agency Date

☐ _____ **has not** been able to
Name of Agency
comply with the decision and order **within 10 days** for the following reasons:

The expected Action Date is: _____
Date Staff Signature Date

☐ I certify that the actions contained in the decision and order **were** completed
after 10 days by: _____ on _____.
Name of Agency Date

☐ _____ **will never** be able to
Name of Agency
comply with the decision and order for the following reasons:

Staff Signature Date

SECTION 3 – Signatures:

Prepared By: (Name and Title)	Date	Phone Number
Supervisor Signature	Date	Phone Number

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs, or disability.

AUTHORITY: 42 CFR 431.200 – 431.250
COMPLETION: Is Voluntary
CONSEQUENCE: None

COPY DISTRIBUTION: WHITE - Administrative Tribunal
YELLOW - DCH / Agency
PINK - DCH / Agency